NEW JERSEY STATE HEALTH BENEFITS PROGRAM — CHAPTER 375 APPLICATION FOR COVERAGE OF CHILD UP TO AGE 30

H0-0763-0906

1. COVERED CHILD'S INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number ___ - ___ - ____

Last Name _____ Title (Jr., Sr., etc.) ___

First Name _____ MI ___

Street Address (Include Apartment #) _____

City _____ State ___ ZIP Code + 4 _____ - ____

Date of Birth (mm/dd/yy) ____ Gender (M/F) ___ (Area Code) ___ Home Telephone Number ___ - ____

Relationship to Employee/Retiree (Check One)

☐ -Natural Child ☐ -Adopted ☐ -Stepchild ☐ -Other (explain) _____

DIVISION USE ONLY

Effective Dates:

H _____ _____ _____

P _____ _____ _____

Location # ____

Note: Eligibility in the SHBP (Chapter 375, P.L. 2005) is limited to a child under the age of 30; who is unmarried; has no dependent(s) of his/her own; is a resident of New Jersey or a full time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Coverage is limited to the SHBP medical and prescription drug plans that are identical to the plans in which the parent is enrolled. The covered parent is responsible for the entire cost of coverage.

2. COVERED PARENT'S INFORMATION

Social Security Number ___ - ___ - ____

Last Name _____

First Name _____

Date of Birth (mm/dd/yy) ____

(Area Code) ___ Home Telephone Number ___ - ___ - ____

3. BILLING ADDRESS - If different from child's address

Street Address (Include Apartment #) _____

City _____

State ___ ZIP Code + 4 _____ - ____

4. COVERAGE ELECTION

To select coverage indicate with an **X** in the appropriate box.
If terminating coverage indicate with an **X** in the appropriate box.

☐ **I wish to be ENROLLED FOR CHAPTER 375 COVERAGE**
(Must be the same coverage as parent's)

a. Name of Plan _____

b. If NJ PLUS or an HMO, list the Physician ID Number

____

☐ **I wish to TERMINATE ALL COVERAGE under Chapter 375, P.L. 2005**

5. I CERTIFY that all the information supplied on this form is true to the best of my knowledge. I hereby make application to extend group insurance coverage under the terms Chapter 375, P.L. 2005. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments and further agree to make further payments in a timely fashion. I understand this coverage will terminate without notice if payment is not made on time. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors, hospitals, or other facilities in the NJ PLUS or HMO plans. If my physician or medical center terminates participation in my selected plan, I must elect another doctor or medical center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered child as the assignee may require. I agree to notify the State Health Benefits Program if my covered child becomes covered under another group health plan or become entitled to Medicare after electing coverage under Capter 375, or otherwise becomes ineligible for any other reason (see Note above).

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

_____ _____
Covered Parent's Signature Date Completed

_____ _____
Covered Child's Signature Date Completed

DO NOT SEND PAYMENT WITH APPLICATION — YOU WILL BE BILLED

COMPLETING THE STATE HEALTH BENEFITS PROGRAM CHAPTER 375 APPLICATION FOR COVERAGE OF OVER AGE CHILD UP TO AGE 30

Under the provisions of Chapter 375, P.L. 2005, certain over age children may be eligible for coverage under the State Health Benefits Program (SHBP) until age 30. This includes a child by blood or law who: is under the age of 30; unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare. An over age child is eligible for coverage in the SHBP medical and prescription drug plans that are identical to the plans in which the covered parent is enrolled. The covered parent is responsible for the entire cost of coverage (see Section 3 below for details).

SECTION 1 — COVERED CHILD'S INFORMATION

This section pertains to the child enrolling in the Chapter 375 coverage. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth (for example: April 12, 1980 = 04 12 80). Please be certain to indicate the specific relationship to the covered parent (natural child, adopted, stepchild, etc.).

SECTION 2 — COVERED PARENT'S INFORMATION

This section pertains to the covered parent under whom regular SHBP dependent child coverage eligibility has ended. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth (for example: March 22, 1957 = 03 22 57). Please also include a home telephone number for the covered parent.

SECTION 3 — BILLING ADDRESS

List the complete mailing address where the SHBP should send the monthly bill for chapter 375 premium payment. The covered parent is responsible for the entire cost of coverage. When Chapter 375 coverage is elected, the covered parent will be billed directly by the SHBP for the cost of the coverage. Chapter 375 rates for all SHBP plans are available over the Internet at: *www.state.nj.us/treasury/ pensions/shbp.htm*

SECTION 4 — COVERAGE ELECTION

Check the appropriate box(es) indicating:

- that you wish to enroll for Chapter 375 coverage (if coverage is in NJ PLUS or an HMO you must list the identification number of your Primary Care Physician); or
- that you wish to terminate all coverage under Chapter 375.

SECTION 5 — CERTIFICATION AND SIGNATURE

Both the Chapter 375 covered child and the SHBP covered parent must read the certification and sign and date the application.

Misrepresentation: Any person who provides false or misleading information is subject to criminal and civil penalties.

Return this application and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. BOX 299
TRENTON, NJ 08625-0299
or Fax to: (609) 341-3407